Big changes coming to QIO Program

The Centers for Medicare & Medicaid Services (CMS) is restructuring the nation’s Quality Improvement Organization program in two phases.

Phase 1, announced recently, will separate the QIOs’ traditional quality improvement activities from their review work. CMS has selected two Beneficiary and Family-centered Care (BFCC) contractors to cover review activities – Maryland-based Livanta LLC and Ohio-based KEPRO. They will assist Medicare beneficiaries with complaint reviews, quality of care reviews, discharge appeals, higher weighted diagnostic related groups (DRG) requests and Emergency Medical Treatment and Active Labor Act (EMTALA) reviews.

Livanta will work with the states in the Northeast and the Pacific Northwest, along with Alaska, Hawaii and the Virgin Islands, while KEPRO will work with states in the South, Midwest and West, including Georgia. The redesign of the QIO Program will not lessen the contractual obligations of the QIOs to meet the local needs of their constituents. CMS will continue to monitor and evaluate QIO contractors based on their performance in each state to ensure that contract responsibilities are fulfilled.

Providers: No change in the process until August 1, 2014

What this means for Medicare Providers
What this means for Medicare Beneficiaries

In Phase 2, starting August 1, the current 53 federally contracted companies will be reduced to 12-17 Quality Innovation Network (QIN) QIO contracts. The QIN organizations will work with providers to improve patient care, reduce harm and improve clinical care and transparency. Alliant GMCF, the Medicare QIO for Georgia, has applied to continue performing this work for Georgia. We will provide more details on this transition as they become available.
What this means for Providers

Overview of Transition

CMS has restructured the QIO Program from its historical 53 contracts, in which each QIO performs both case review and quality improvement support for each state or territory, to a regional structure for case review and an industry-determined service structure for quality improvement initiatives.

No change in the process until August 1

In the new structure, case review and quality improvement functions are performed by different contractors, the contract periods are extended from 3 to 5 years, and there is enhanced focus on learning, collaboration and the dissemination of best practices.

KEPRO, the Beneficiary and Family Centered Care Quality Improvement Organizations (BFCC-QIO) covering Georgia, will assist Medicare beneficiaries with complaint reviews, quality of care reviews, discharge appeals, higher weighted diagnostic related groups (DRG) requests and Emergency Medical Treatment and Active Labor Act (EMTALA) reviews. This will ensure consistency in the review process while taking into consideration local factors important to beneficiaries and their families.

Quality Innovation Network (QIN) QIOs are responsible for working with providers and the community on multiple, data-driven quality initiatives to improve patient safety, reduce harm, and improve clinical care at their local and regional levels.

Quality Case Review and Appeals after July 31

On August 1, 2014, all current and future beneficiary quality review case work and appeals will be conducted by KEPRO, 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609

Provider Helpline during transition period: 1-800-385-5080

If a patient’s case is currently under review or in process, every effort has been made to ensure a seamless transition for beneficiaries with no disruption in case review services.

Please begin using this revised notice to beneficiaries on August 1.
QIO changes to affect Medicare Beneficiaries

QIOs are organizations that are available to help you when you have questions about whether you are ready for discharge from a hospital, nursing home, rehab facility, home health agency or hospice. You may have a concern about whether a health care service should be ended or whether you should have been transferred from an Emergency Department to another hospital or to home. They also are available to review a quality of care concern that you or your family may have about the care that you receive from your hospital, doctor, nurse or others.

Medicare has made some changes to the program to ensure that your needs are better met by designating a special QIO just to address beneficiary and family concerns.

KEPRO will manage all beneficiary complaints, appeals and quality of care reviews from Georgia.

Quality Case Review and Appeals after July 31

On August 1, 2014, all beneficiary quality review case work and appeals will be conducted by KEPRO, 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609

Their Beneficiary Helpline is: 1-844-455-8708

If your case is currently under review or in process, every effort has been made to ensure a seamless transition for Medicare beneficiaries with no disruption in case review services.

For more information on the QIO Program, call 1-800-MEDICARE.
An Important Message From Medicare About Your Rights

As A Hospital Inpatient, You Have The Right To:

• Receive Medicare covered services. This includes medically necessary hospital services and services you may need after you are discharged, if ordered by your doctor. You have a right to know about these services, who will pay for them, and where you can get them.

• Be involved in any decisions about your hospital stay, and know who will pay for it.

• Report any concerns you have about the quality of care you receive to the Quality Improvement Organization (QIO) listed here:

Name of QIO

Telephone Number of QIO

Your Medicare Discharge Rights

Planning For Your Discharge: During your hospital stay, the hospital staff will be working with you to prepare for your safe discharge and arrange for services you may need after you leave the hospital. When you no longer need inpatient hospital care, your doctor or the hospital staff will inform you of your planned discharge date.

If you think you are being discharged too soon:

• You can talk to the hospital staff, your doctor and your managed care plan (if you belong to one) about your concerns.

• You also have the right to an appeal, that is, a review of your case by a Quality Improvement Organization (QIO). The QIO is an outside reviewer hired by Medicare to look at your case to decide whether you are ready to leave the hospital.

  □ If you want to appeal, you must contact the QIO no later than your planned discharge date and before you leave the hospital.

  □ If you do this, you will not have to pay for the services you receive during the appeal (except for charges like copays and deductibles).

• If you do not appeal, but decide to stay in the hospital past your planned discharge date, you may have to pay for any services you receive after that date.

• Step by step instructions for calling the QIO and filing an appeal are on page 2.

To speak with someone at the hospital about this notice, call ____________________________.

Please sign and date here to show you received this notice and understand your rights.

Signature of Patient or Representative  Date/Time

Form CMS-R-193 (approved 07/10)
Steps To Appeal Your Discharge

- **Step 1:** You must contact the QIO no later than your planned discharge date and before you leave the hospital. If you do this, you will not have to pay for the services you receive during the appeal (except for charges like copays and deductibles).

  ▪ Here is the contact information for the QIO:

    | Name of QIO (in bold) |
    | Telephone Number of QIO |

  ▪ You can file a request for an appeal any day of the week. **Once you speak to someone or leave a message, your appeal has begun.**

  ▪ Ask the hospital if you need help contacting the QIO.

  ▪ The name of this hospital is:

    | Hospital Name | Provider ID Number |

- **Step 2:** You will receive a detailed notice from the hospital or your Medicare Advantage or other Medicare managed care plan (if you belong to one) that explains the reasons they think you are ready to be discharged.

- **Step 3:** The QIO will ask for your opinion. You or your representative need to be available to speak with the QIO, if requested. You or your representative may give the QIO a written statement, but you are not required to do so.

- **Step 4:** The QIO will review your medical records and other important information about your case.

- **Step 5:** The QIO will notify you of its decision within 1 day after it receives all necessary information.

  ▪ If the QIO finds that you are not ready to be discharged, Medicare will continue to cover your hospital services.

  ▪ If the QIO finds you are ready to be discharged, Medicare will continue to cover your services until noon of the day after the QIO notifies you of its decision.

If You Miss The Deadline To Appeal, You Have Other Appeal Rights:

- You can still ask the QIO or your plan (if you belong to one) for a review of your case:

  ▪ If you have Original Medicare: Call the QIO listed above.

  ▪ If you belong to a Medicare Advantage Plan or other Medicare managed care plan: Call your plan.

- If you stay in the hospital, the hospital may charge you for any services you receive after your planned discharge date.

For more information, call 1-800-MEDICARE (1-800-633-4227), or TTY: 1-877-486-2048.

Additional Information:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0692. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
Completing The Notice

Page 1 of the Important Message from Medicare

A. Header

Hospitals must display “Department of Health & Human Services, Centers for Medicare & Medicaid Services” and the OMB number.

The following blanks must be completed by the hospital. Information inserted by hospitals in the blank spaces on the IM may be typed or legibly hand-written in 12-point font or the equivalent. Hospitals may also use a patient label that includes the following information:

Patient Name: Fill in the patient’s full name.

Patient ID number: Fill in an ID number that identifies this patient. This number should not be, nor should it contain, the social security number.

Physician: Fill in the name of the patient’s physician.

B. Body of the Notice

Bullet number 3 – Report any concerns you have about the quality of care you receive to the Quality Improvement Organization (QIO) listed here __________________________.

Hospitals may preprint or otherwise insert the name and telephone number (including TTY) of the QIO.

To speak with someone at the hospital about this notice call: Fill in a telephone number at the hospital for the patient or representative to call with questions about the notice. Preferably, a contact name should also be included.

Patient or Representative Signature: Have the patient or representative sign the notice to indicate that he or she has received it and understands its contents.

Date/Time: Have the patient or representative place the date and time that he or she signed the notice.

Page 2 of the Important Message from Medicare

First sub-bullet – Insert name and telephone number of QIO in bold: Insert name and telephone number (including TTY), in bold, of the Quality Improvement Organization that performs reviews for the hospital.

Second sub-bullet – The name of this hospital is: Insert/preprint the name of the hospital, including the Medicare provider ID number (not the telephone number).

Additional Information: Hospitals may use this section for additional documentation, including, for example, obtaining beneficiary initials, date, and time to document delivery of the follow-up copy of the IM, or documentation of refusals.